VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates:
Screen: ____/____/________
Assessment: ____/____/________
Reassessment: ____/____/________

IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: ______________________________ Client SSN: ______________
(Last) *(First)* *(Middle Initial)*

Address: ____
(Street) *(City)* *(State)* *(Zip Code)*

Phone: ____________________ City/County Code: ______________

Directions to House: **Pets?**

Demographics

Birthdate: ____/____/____ **Age:** ____________ **Sex:** ____ Male $_0$ ____ Female $_1$
(Month) *(Day)* *(Year)*

Marital Status: ____ Married $_0$ ____ Widowed $_1$ ____ Separated $_2$ ____ Divorced $_3$ ____ Single $_4$ ____ Unknown $_9$

Race:
____ White 0
____ Black/African American 1
____ American Indian 2
____ Oriental/Asian 3
____ Alaskan Native 4
____ Unknown 9 ____________
Ethnic Origin: ____________

Education:
____ Less than High School 0
____ Some High School 1
____ High School Graduate 2
____ Some College 3
____ College Graduate 4
____ Unknown 9
Specify: ____________

Communication of Needs:
____ Verbally, English 0
____ Verbally, Other Language 1
____ Specify: ____________
____ Sign Language/Gestures/Device 2
____ Does Not Communicate 3
Hearing Impaired? ____________

Primary Caregiver/Emergency Contact/Primary Physician

Name: ____________ Relationships: ____________
Address: ____________ Phone: (H) ________ (W) ________
Name: ____________ Relationship: ____________
Address: ____________ Phone: (H) ________ (W) ________
Name of Primary Physician: ____________ Phone: ____________
Address: ____________

Initial Contact

Who called: ____
(Name) *(Relation to Client)* *(Phone)*

Presenting Problem/Diagnosis:

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Client Name: Client SSN:

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*(Check All Services That Apply)*	Provider/Frequency:
		Adult Day Care	
		Adult Protective	
		Case Management	
		Chore/Companion/Homemaker	
		Congregate Meals/Senior Center	
		Financial Management/Counseling	
		Friendly Visitor/Telephone Reassurance	
		Habilitation/Supported Employee	
		Home Delivered Meals	
		Home Health/Rehabilitation	
		Home Repairs/Weatherization	
		Housing	
		Legal	
		Mental Health (Inpatient/Outpatient)	
		Mental Retardation	
		Personal Care	
		Respite	
		Substance Abuse	
		Transportation	
		Vocational Rehab/Job Counseling	
		Other:	

Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

	Annual	Monthly
______	$20,000 or More	($1,667 or more) 0
______	$15,000 - 19,999	($1,250 - $1,666) 1
______	$11,000 - 14,999	($ 917 - $1,249) 2
______	$ 9,500 - 10,999	($ 792 - $ 916) 3
______	$ 7,000 - 9,499	($ 583 - $ 791) 4
______	$ 5,500 - 6,999	($ 458 - $ 582) 5
______	$ 5,499 or Less	($ 457 or Less) 6
______	Unknown 9	

Number in Family unit: ________________

Optional: Total monthly family income: ________________

Do you currently receive income from…?

No 0	Yes 1		*Optional: Amount*
		Black Lung	
		Pension	
		Social Security	
		SSI/SSDI	
		VA Benefits	
		Wages/Salary	
		Other	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		*Names*
		Legal Guardian	
		Power of Attorney	
		Representative Payee	
		Other	

Do you receive any benefits or entitlements?

No 0	Yes 1	
		Auxiliary Grant
		Food Stamps
		Fuel Assistance
		General Relief
		State and Local Hospitalization
		Subsidized Housing
		Tax Relief

What types of health insurance do you have?

No 0	Yes 1		
		Medicare, #	
		Medicaid, #	
		Pending:	____ No 0 ____ Yes 1
		QMB/SLMB:	____ No 0 ____ Yes 1
		All Other Public/Private:	

Client Name:	Client SSN:

Physical Environment

Where do you usually live? Does anyone live with you?

		Alone $_1$	Spouse $_2$	Other $_3$	Names of Persons in Household
____	House: Own $_0$				
____	House: Rent $_1$				
____	House: Other $_2$				
____	Apartment $_3$				
____	Rented Room $_4$				

		Name of Provider *(Place)*	Admission Date	Provider Number *(If Applicable)*
____	Adult Care Residence $_{50}$			
____	Adult Foster $_{60}$			
____	Nursing Facility $_{70}$			
____	Mental Health/Retardation Facility $_{80}$			
____	Other $_{90}$			

Where you usually live are there any problems?

No $_0$	Yes $_1$	*(Check All Problems That Apply)*	Describe Problems:
______	______	Barriers to Access	
______	______	Electric Hazards	
______	______	Fire Hazards/No Smoke Alarm	
______	______	Insufficient Heat/Air Conditioning	
______	______	Insufficient Hot Water/Water	
______	______	Lack of/Poor Toilet Facilities (Inside/Outside)	
______	______	Lack of/Defective Stove, Refrigerator, Freezer	
______	______	Lack of/Defective Washer/Dryer	
______	______	Lack of/Poor Bathing Facilities	
______	______	Structural Problems	
______	______	Telephone Not Accessible	
______	______	Unsafe Neighborhood	
______	______	Unsafe/Poor Lighting	
______	______	Unsanitary Conditions	
______	______	Other: ______________________	

Client Name:	Client SSN:

2 FUNCTIONAL STATUS *(Check only one block for each level of functioning.)*

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40			Is Not D .Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External D Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6
	No 00	Yes						
Bowel								
Bladder								

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

_____ No, Continue with Section 3 (0) _____ Yes, Service Referrals (1) _____ Yes, No Service Referrals (2)

Screener: ______________________ Agency: ______________________

Client Name:	Client SSN:

PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No $_0$	Yes $_1$		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as… (Who has it…Where is it…)?

No $_0$ Yes $_1$ *Location*

______ ______ Living Will, ______

______ ______ Durable Power of Attorney for Health Care, ______

______ ______ Other, ______

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as … (Refer to the list of diagnoses)?

Current Diagnoses **Date of Onset**

______ ______

______ ______

______ ______

______ ______

______ ______

______ ______

Enter Codes for 3 Major, Active Diagnoses: _____ **None$_{00}$** _____ **DX1** _____ **DX2** _____ **DX3**

Current Medications (Include Over-the-Counter)	**Dose, Frequency, Route**	**Reason(s) Prescribed**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Total No. of Medications: _______ **(If 0, skip to Sensory Function)** **Total No. of Tranquilizer/Psychotropic Drugs:** __________

Do you have any problems with medicine(s)…?

No $_0$ Yes $_1$

______ ______ Adverse reactions/allergies

______ ______ Cost of medication

______ ______ Getting to the pharmacy

______ ______ Taking them as instructed/prescribed

______ ______ Understanding directions/schedule

How do you take your medications?

_______ Without assistance 0

_______ Administered/monitored by lay person 1

_______ Administered/monitored by professional nursing staff 2

Describe help: ______

Name of helper: ______

Diagnoses:
- Alcoholism/Substance Abuse (01)
- Blood-Related Problems (02)
- Cancer (03)
- Cardiovascular Problems
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- Dementia
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- Developmental Disabilities
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich'a Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland)Problems
  - Diabetes (19)
  - Other Endocrine Problem (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- Neurological Problems
  - Brian Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- Psychiatric Problems
  - Anxiety Disorder (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- Respiratory Problems
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- Urinary/Reproductive Problems
  - Renal Failure (40)
  - Other Urinary /Reproductive (41)
- All Other Problems (42)

Client Name:	Client SSN:

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment $_0$	Impairment *Record Date of Onset/Type of Impairment*		Complete Loss $_3$	Date of Last Exam
		Compensation $_1$	No Compensation $_2$		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers, and legs?

________ Within normal limits or instability corrected $_0$
________ Limited motion $_1$
________ Instability uncorrected or immobile $_2$

Have you ever broken or dislocated any bones … Ever had an amputation or lost any limbs … Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
____ None 000	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: ____________
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

Nutrition

Height: __________ *(Inches)* Weight: __________ *(lbs.)* Recent Weight Gain/Loss: ____ No $_0$ ____ Yes $_1$
Describe: ____________________

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No $_0$	Yes $_1$	
____	____	Food Allergies
____	____	Inadequate Food/Fluid Intake
____	____	Nausea/Vomiting/Diarrhea
____	____	Problems Eating Certain Foods
____	____	Problems Following Special Diets
____	____	Problems Swallowing
____	____	Taste Problems
____	____	Tooth or Mouth Problems
____		Other: ____________

Client Name: *Client SSN:*

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as…?

No $_0$	Yes $_1$		*Frequency*
___	___	Occupational	___
___	___	Physical	___
___	___	Reality/Remotivation	___
___	___	Respiratory	___
___	___	Speech	___
___	___	Other	___

Do you have pressure ulcers?

		Location/Size
___	None 0	
___	Stage I 1	___
___	Stage II 2	___
___	Stage III 3	___
___	Stage IV 4	___

Special Medical Procedures: Do you receive any special nursing care, such as …?

No $_0$	Yes $_1$		*Site, Type, Frequency*
___	___	Bowel/Bladder Training	___
___	___	Dialysis	___
___	___	Dressing/Wound Care	___
___	___	Eye care	___
___	___	Glucose/Blood Sugar	___
___	___	Injections/IV Therapy	___
___	___	Oxygen	___
___	___	Radiation/Chemotherapy	___
___	___	Restraints (Physical/Chemical)	___
___	___	ROM Exercise	___
___	___	Trach Care/Suctioning	___
___	___	Ventilator	___
___	___	Other:	___

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ______ No $_0$ ______ Yes $_1$

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: ______________________ Date: ______________

Others: ______________________ Date ______________

(Signature/Title)

Client Name: *Client SSN:*

PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: Please tell me your full name (so that I can make sure our record is correct).
Place: Where are we now (*state, county, town, street/route number, street name/box number*)? *Give the client 1 point for each correct response.*
Time: Would you tell me the date today *(year, season, date, day, month)*?

_____ Oriented 0
_____ Disoriented – Some spheres, some of the time 1
_____ Disoriented – Some spheres, all the time 2
_____ Disoriented – All spheres, some of the time 3
_____ Disoriented – All spheres, all of the time 4
_____ Comatose 5

Spheres affected: ______________________

Recall/Memory/Judgment

Recall: I am going to say three words. And I want you to repeat them after I am done (House, Bus,Dog). * Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* * Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: * Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgment: If you needed help at night, what would you do?

Optional: MMSE Score
(5)
(5)
(3)
(5)
Total:
Note: Score of 14 or below implies cognitive impairment.

No 0	Yes 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc…) or become agitated and abusive?

_____ Appropriate 0
_____ Wandering/Passive – Less than weekly 1
_____ Wandering/Passive – Weekly or more 2
_____ Abusive/Aggressive/Disruptive – Less than weekly 3
_____ Abusive/Aggressive/Disruptive – Weekly or more 4
_____ Comatose 5

Type of inappropriate behavior: ______________________ Source of Information: ______________________

Life Stressors

Are there any stressful events that currently affect your life, such as …?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
_____	_____	Change in work/employment	_____	_____	Financial problems	_____	_____	Victim of a crime
_____	_____	Death of someone close	_____	_____	Major illness- family/friend	_____	_____	Failing health
_____	_____	Family conflict	_____	_____	Recent move/relocation	_____	_____	Other: _____

Client Name:	*Client SSN:*

Emotional Status

In the past month, how often did you …?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living … or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite … that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

_______ _________ Solitary Activities, ____________________

_______ _________ With Friends/Family, ____________________

_______ _________ With Groups/Clubs, ____________________

_______ _________ Religious Activities, ____________________

How often do you talk with your children family or friends either during a visit or over the phone?

Children	**Other Family**	**Friends/ Neighbors**
________ No Children 0	________ No Other Family 0	________ No Friends/Neighbors 0
________ Daily 1	________ Daily 1	________ Daily 1
________ Weekly 2	________ Weekly 2	________ Weekly 2
________ Monthly 3	________ Monthly 3	________ Monthly 3
________ Less than Monthly 4	________ Less than Monthly 4	________ Less than Monthly 4
________ Never 5	________ Never 5	________ Never 5

Are you satisfied with how often you see or hear from your children other family and/or friends?

________ No 0 _________ Yes 1

Client Name: *Client SSN:*

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?

_______ No $_0$ _______ Yes $_1$

Name of Place	Admit Date	Length of stay/Reason

Do (did) you ever drink alcoholic beverages?

_______ Never 0
_______ At one time, but no longer 1
_______ Currently 2
How much: ____________________________
How often: ____________________________

Do (did) you ever use non-prescription, mood altering substances?

___________ Never 0
___________ At one time, but no longer 1
___________ Currently 2
How much: ____________________________________
How often: ____________________________________

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with …	Do (did) you ever use alcohol/other mood-altering substances to help you …
_____ No $_0$ _____ Yes $_1$	No $_0$ Yes $_1$	No $_0$ Yes $_1$
	_____ _____ Prescription drugs?	_____ _____ Sleep?
Describe concerns:	_____ _____ OTC medicine?	_____ _____ Relax?
	_____ _____ Other substances?	_____ _____ Get more energy?
		_____ _____ Relieve worries?
	Describe what and how often:	_____ _____ Relieve physical pain?
		Describe what and how often:

Do (did) you ever smoke or use tobacco products?

________ Never 0
________ At one time, but no longer 1
________ Currently 2
How much: ____
How often: ____

Is there anything we have not talked about that you would like to discuss?

Client Name:	Client SSN:

Assessment Summary

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

______ No $_0$ (Skip to Section on Preferences) ______ Yes $_1$

Where does the caregiver live?

______ With client 0
______ Separate residence, close proximity 1
______ Separate residence, over 1 hour away 2

Is the caregiver's help …

______ Adequate to meet the client's needs? 0
______ Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

______ Not at all 0
______ Somewhat 1
______ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preference for receiving needed care: ______________________________

____

____

Family/Representative's preference for client's care: ______________________________

____

____

Physician's comments (if applicable): ______________________________

____

____

Client Name:	*Client SSN:*

Client Case Summary

Unmet Needs

No 0	Yes 1	*(Check All That Apply)*	No 0	Yes 1	*(Check All That Apply)*
______	______	Finances	______	______	Assistive Devices/Medical Equipment
______	______	Home/Physical Environment	______	______	Medical Care/Health
______	______	ADLS	______	______	Nutrition
______	______	IADLS	______	______	Cognitive/Emotional
			______	______	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: **Case assigned to:** ______________________________ **Code #:** ______________________________